MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

APPLICATION FOR RENEWAL OF LICENSURE OF AMBULATORY SURGICAL FACILITIES

For Period: _____ to _____

1. ***Name of Facility***: _____

Doing Business As: _____

Located At: _____
Street or Road/City or Town/Zip Code

_____
County Telephone Number

E-Mail Address: _____

2. ***Directions for Reaching Facility*** (If there are any changes in addresses, please attach specific directions-Draw a map, if possible): _____

_____

_____

3. ***Mailing Address, if Different***:

_____
Street/Road City/Town Zip Code County

4. ***Ownership*** (Name & Address of Owner(s)—Individual, Partners, Corporation):

Name: _____

_____

Identification Number: _____
(Owner's Social Security No. or IRS Identification No.)

INSTRUCTIONS

A. If Sole Proprietor, list name of owner (see A on Page 2;

B. For business entities with Business Partnerships, the full name and address of each partner (see B on Page 2);

C. If Proprietary Corporation, list the name, address and titles of each person, firm or corporation, having (directly/indirectly) an ownership of 5% or more in the facility (see C on Page 2);

D. For Not-For-Profit organizations, list the name and address of the President of the Board of Directors or appropriate municipal government representative (see D on Page 2);

E. What is your Fiscal Year End date: _____

Type of Entity

A. ☐ Sole Proprietorship

B. ☐ Partnership

C. ☐ Corporation

D. ☐ Not-For-Profit

E. ☐ Other (specify) _____

If Sole Proprietorship, list name of owner: _____

If Partnership, list names and addresses of partners or organizations have direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name Address

_____
_____
_____
_____
_____

If the Disclosing Entity is a Corporation, list names, addresses and titles of the Officers or Directors.

A. Officer's Name Title Address

_____
_____
_____
_____

B. Director's Name Title Address

_____
_____
_____
_____

If the Disclosing Entity is a Not-For-Profit Organization, list name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name Address

_____

_____

5. ***If the building(s) used by the Ambulatory Surgical Facility is/are leased***, a copy of each lease shall be attached to this application. Not needed if at the same site(s) and met the previous year.

6. ***Name and title of the person in charge***: _____

_____

Home Address Home Telephone No./Office Telephone No.

7. **The Ambulatory Surgical Facility** ☐ is (or) ☐ is not Medicare Certified.

The Ambulatory Surgical Facility has been open since _____
(Date)

8. Location of all Facilities/Subunits utilized by the Ambulatory Surgical Facility:

Address	Telephone No.	Name of Owner of The Building
(1)		
(2)		
(3)		
(4)		

9. ***Please attach a letter from appropriate Municipal official(s)*** that demonstrates compliance with all local ordinances relative to zoning and building regulations. (Only needed if there has been a change of address).

10. ***Please send a list of procedures performed at the Ambulatory Surgical Facility.***

11. Total number of full-time equivalent staff employed by the Facility: _____

(All employees of the Ambulatory Surgical Facility, including administrative, business, clerical and direct services providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37½ hours per week for the Ambulatory Surgical Facility. Total the hours of all employees for one week then divide by 37.5. This equals the number of full-time equivalent employees. Both individuals directly employed and those contracted by the Facility shall be counted in the calculation of the facility's full-time equivalent figure.)

12. ***Fees.*** (Enclose a check with the application in accordance with the fee schedule below):

A. Basic fee of $250.00 for all licensure applicants.

B. An additional fee based on the table below:

0-10 Total Full-Time Equivalent Employees	=	$100.00
10-25 Total Full-Time Equivalent Employees	=	$175.00
26 or over Total Full-Time Equivalent Employees	=	$250.00

Make checks payable to the Treasurer, State of Maine, and mail the fee and application to the Division of Licensing and Regulatory Services, Medical Facilities Unit, 41 Anthony Avenue, #11 SHS, Augusta, ME 04333-0011.

13. IS THIS AMBULATORY SURGICAL CENTER ACCREDITED?

_____ JCAHO _____ CHAPS _____ AAAHC ___ OTHER

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health & Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure. License is granted subject to survey findings.

I, _____, BEING DULY AUTHORIZED TO ASSUME RESPONSIBILITY FOR THE CONDUCT OF THE FACILITY HEREIN DESCRIBED, DO HEREBY APPLY FOR A LICENSE TO OPERATE THE FACILITY AND DO AGREE TO ASSUME RESPONSIBILITY THAT THE FACILITY WILL COMPLY WITH ALL THE CURRENT REGULATIONS OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES, AS AUTHORIZED BY TITLE 22, M.R.S.A., §2141-2148, AND M.R.S.A. §42.

_____ _____

Date Signature of Provider (Administrator)

FOR OFFICE USE ONLY:

FEE_____
Checked by_____
Check No._____